U.S. DEPARTMENT OF HEALTH & HUMAN SERVICESFORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0679
CERTIFICATE OF MEDICAL NECESSITY DMERC 07.02B
POWER OPERATED VEHICLE (POV)
SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN
SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ NSC #
PLACE OF SERVICE
NAME and ADDRESS of FACILITY if applicable (See
Reverse)
HCPCS CODES: PT DOB _____/_____/_____; Sex _____ (M/F) ; HT._____(in.) ;
WT._____(lbs.)
PHYSICIAN NAME, ADDRESS (Printed or Typed)
PHYSICIAN'S UPIN:
PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9):
ANSWERS ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV)
(Circle Y for Yes, N for No, or D for Does Not Apply)
Questions 1 - 5, and 9 - 11, reserved for other or future use.
Y N D 6. Does the patient require a POV to move around in their residence?
Y N D 7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
Y N D 8. Does the patient require a POV only for movement outside their residence?
Y N D 12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or
rheumatology?
Y N D 13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or
rheumatology?
Y N D 14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery,
neurology, or rheumatology?
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: TITLE: EMPLOYER:
SECTION C Narrative Description Of Equipment And Cost
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule
Allowance for each item, accessory, and option. (See Instructions On Back)
SECTION D Physician Attestation and Signature/Date
I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges
for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that
section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS 850 (4/96)

SECTION A: (May be completed by the supplier)
CERTIFICATION If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked
TYPE/DATE: "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's
changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification
date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked
"INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a
REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or
RECERTIFICATION date.
PATIENT Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN)
INFORMATION: as it appears on his/her Medicare card and on the claim form.
SUPPLIER Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier
INFORMATION: Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE: Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage
Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification
should not be listed on the CMN.
PATIENT DOB, HEIGHT, Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
WEIGHT AND SEX:
PHYSICIAN NAME, Indicate the physician's name and complete mailing address.
ADDRESS:
UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S Indicate the telephone number where the physician can be contacted (preferably where records would be accessible
TELEPHONE NO: pertaining to this patient) if more information is needed.
SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or aphysician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)
EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item)
by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of
his/her life, then enter 99.
DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes
that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to
the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or

fill in the blank if other information is requested.
NAME OF PERSON If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician),
ANSWERING SECTION B or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title
QUESTIONS: and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C: (To be completed by the supplier)
NARRATIVE Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs;
DESCRIPTION OF (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for
EQUIPMENT & COST: each item/option/accessory/supply/drug, if applicable.
SECTION D: (To be completed by the physician)
PHYSICIAN The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answersATTESTATION: in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN inAND DATE: Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are
medically necessary for this patient. Signature and date stamps are not acceptable.
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this
information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing
resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please
write to: CMS, 7500 Security Blvd., N2-14-26, Baltimore, Maryland 21244-1850.s